MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Liberty Mutual Insurance Co. Box: 28 2875 Browns Bridge Rd. Gainesville, GA 30503	MDR Tracking No.: M4-04-4065-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Ortho Rehab Associates P.O. Box 1322 Addison, TX 75001	Date of Injury: Employer's Name: Luxottica US Holdings Corp. Insurance Carrier's No.: 949350251

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/07/03	05/07/03	22899-85	$1539.45	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor states that this overpayment occurred because CPT 22899-85 billed $1,917.00. The amount paid at 100% with a PPO discount take was $1,629.45. The CPT Code is a DOP and should have been paid at 10% of the primary surgeons fair and reasonable rate that was $1,000.00 for a cage enplated.

PART IV: RESPONDENT'S POSITION SUMMARY

No Position Summary submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per Rule 133.304(p), an insurance carrier may request medical dispute resolution in accordance with §133.305 if the insurance carrier did not earlier make full payment on the medical bill in accordance with §413.031 of the Texas Labor Code.

The insurance carrier filed for medical dispute resolution on November 24, 2003 (refund requet). Review of the files reveals that on May 20, 2003, the provider billed the carrier $1,917.00 for CPT Code 22899-85 rendered on May 7, 2003. On June 23, 2004, the insurance carrier made full payment in the amount of $1,629.45 (PPO discount) to the provider for the disputed service. Therefore, the Medical Review Division declines to issue a refund order.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to refund reimbursement.

Decision by:

	Marguerite Foster	May 25, 2005
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____